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ABSTRACT

The results of a survey of physicians actively involved at the state level in policy development for Part H of Public Law 99-457 are reported. A questionnaire was completed by a total of 125 physicians, including physicians identified as Interagency Coordinating Council (ICC) members and physicians who served as state chapter representatives to the American Academy of Pediatrics conference on Public Law 99-457. Examined are the roles physicians have taken in state planning for early intervention services for infants and toddlers with developmental delays, their attitudes toward the eligibility of at-risk children under Part H, their assessment of the relationship between the private health sector and the public human service system, and their perspectives on the major barriers to implementation. Findings included, among others, that six states had no physicians involved in the work of their ICCs; that there was strong consensus in favor of broad-based eligibility criteria; and that physicians reported modest improvement in the relationship between the private health care sector and the public human service system since enactment of the law. Policy implications are outlined. An appendix contains the survey form, and 15 references are cited. (JDD)

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Carolina Institute for Child and Family Policy

PHYSICIAN INVOLVEMENT IN PLANNING FOR P.L. 99-457 PART H: INTERAGENCY COORDINATING COUNCIL ROLES AND SYSTEM PLANNING ISSUES

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EXECUTIVE SUMMARY

PURPOSE

This report presents the results of a survey of physicians actively involved at the state level in policy development for Part H of PL 99-457.

Physician participation in Part H planning is especially important because successful early identification of children in need of services hinges to a large extent on community-based pediatric primary care providers. If Part H policies and procedures for referral and for addressing the special health care needs of eligible children are to be workable in the context of clinical practice, it is critical to involve physicians in planning.

In this study, we examine the roles physicians have taken in state planning for early intervention services for infants and toddlers with developmental delays, their attitudes toward the eligibility of at-risk children under Part H, their assessment of the relationship between the private health sector and the public human service system, and their perspectives on the major barriers to implementation. The goal of this report is to provide lead agencies, ICCs, and interested medical societies with an overview of physician involvement in and opinions about state-level Part H planning and implementation.

METHOD

Data were collected using a written questionnaire that was mailed to physicians identified as ICC members by each state's Part H coordinator. In addition, questionnaires were sent to physicians who were not ICC members but who served as state chapter representatives to the American Academy of Pediatrics' conference on PL 99-457 (November, 1988). A total of 146 physicians were identified and 125 completed the survey in the Spring of 1989, before the Federal Regulations for Part H had been published.

RESULTS IN BRIEF

- Results indicate a keen interest in and commitment to this program among the core group of physicians actively involved in state Part H policy development.
- 6 states had no physicians involved in the work of their ICCs but many states had several physicians on ICCs.
- 24 states had no private community-based practitioners on their ICCs.
- 94% of the ICC physicians were pediatricians.
- There was strong consensus in favor of broad-based eligibility criteria:
  - 100% of the respondents thought <u>at least some biological risk</u> factors should be included; 72% thought <u>all biological risk</u> factors should be included.
  - All but two respondents thought <u>at least some environmental risk</u> factors should be included; 53% thought <u>all environmental risk</u> factors should be included.
  - 50% of the respondents thought <u>all children at-risk</u> (both biological and environmental) should be served.
- ICC physicians reported modest improvement in the relationship between the private health care sector and the public human service system since enactment of PL 99-457.
- Respondents identified several major barriers to full implementation:
  - the low level of funding and current reimbursement policies (64%),
  - the lack of interagency/practitioner coordination, problems of turf, and difficulties in referral (45%), and
  - the lack of appropriately trained personnel and shortage of appropriate services (20%).

POLICY IMPLICATIONS

- It is important for Part H planners to consider how to draw more community-based private physicians into the planning efforts at the state level.
- From the point of view of the family and its physician, much of the work of coordination takes place at the local level. It will be increasingly important to develop and support structures for physician participation in planning and coordination at the local level.
- It is important to involve in Part H planning family practitioners, child psychiatrists, and other types of physicians whose practices bring them into contact with potentially eligible youngsters.
- Part H planners need to identify and seek to address reimbursement policies that discourage physician participation.
- States can collaborate with state and local AAP chapters, state Title V agencies, and the Office of Maternal and Child Health and Programs for Chidren with Special Health Needs to support continuing education for physicians in areas relevant to Part H (e.g., screening, multidisciplinary assessment, community resources, etc.).

INTRODUCTION

Purpose

Effective collaboration among agencies and between public programs and private, community-based providers is essential to the provision of services to very young children with special needs and their families. The Infants and Toddlers Program (Part H) of PL 99-457 establishes a comprehensive program of interagency early intervention services for birth-to-three year-olds experiencing or at-risk for developmental delays. In order to realize fully the goals embodied in the statute of coordinated, multidisciplinary services for all eligible children from the earliest age, the involvement of community-based physicians is critical. Working models for accomplishing such a partnership, especially on a statewide interagency basis, are few: each state must design its own strategies for public/private collaboration under Part H. For this reason, it is crucial to involve community-based physicians when planning the service system under Part H.

This report presents the results of a survey of physicians actively involved at the state level in planning for the implementation of Part H. The study focuses on these physicians' roles in policy development, their attitudes toward the eligibility of at-risk children under Part H, their assessment of the relationship between the private health sector and the public human service system, and their perspectives on the major barriers to implementation. The goal of this report is to provide lead agencies, ICCs, and interested medical societies with an overview of physician involvement in and opinions about state-level Part H planning and implementation.

Background and Context

In late 1986, one of the most far-reaching federal initiatives for very young children was signed into law as PL 99-457. In Part H of this law, (100 STAT., 1145-1155), Congress established a program to assist states in the development of statewide, coordinated,

comprehensive, interagency, and multidisciplinary systems of early intervention services for developmentally delayed infants and toddlers and their families (see Table 1).

At the time of enactment, states varied widely in their policies regarding early intervention and the availability of services for very young children with disabilities (Fraas, 1986; Meisels, Harbin, Modigliani & Olsen, 1988; Hauser-Cram, Upshur, Krauss, & Shonkoff, 1987). Services were typically fragmented across agencies and providers, with inadequate or no coordination among multiple programs and funding sources. Part H addresses the piecemeal approach to early intervention taken in states, requiring them to develop a more accessible program of services that is both comprehensive -- ranging from early identification through developmental treatment for the child and counseling for the family-- and coordinated across agencies, programs, and providers.

Part H recognizes that a comprehensive service delivery system is too complex to fall under the purview of any single agency or provider. Because of this recognition, the program is multidisciplinary and interagency in nature, with several types of provisions designed to facilitate service coordination written into the statute. One mandated mechanism of coordination is the lead agency, which is designated by each state's governor. The lead agency takes responsibility for the supervision of Part H activities and programs, the identification and coordination of all available resources, the assignment of financial responsibility, the development of procedures to ensure the provision of services, the resolution of disputes, and the development of interagency agreements (100 STAT., Sec. 676 (b) (9)). The statute allows states to determine which agency will take the lead for Part H. The 50 state governors have chosen a variety of different lead agencies; among these are education, health, mental health, developmental disabilities, and specially designated multi-agency councils.

The statute also requires each state to have an Interagency Coordinating Council (ICC) to facilitate coordinated planning. Appointed by the governor, the ICC membership must include at least three parents of very young children with handicaps, three public or private providers, one representative of the state legislature, an individual involved in personnel preparation, and

Table 1. Minimum Components of PL 99-457, Part H

1. Definition of developmentally delayed
2. Timetable for serving all in need in the state
3. Comprehensive multidisciplinary evaluation of needs of children and families
4. Individualized family service plan and case management services
5. Child find and referral system
6. Public awareness
7. Central directory of services, resources, experts, research and demonstration projects.
8. Comprehensive system of personnel development
9. Single line of authority in a lead agency designated or established by the governor for implementation of:
   a. general administration and supervision
   b. identification and coordination of all available resources
   c. assignment of financial responsibility to the appropriate agency
   d. procedures to ensure the provision of services and to resolve intra- and interagency disputes
   e. entry into formal interagency agreements
10. Policy pertaining to contracting or making arrangements with local service providers
11. Procedure for timely reimbursement of funds
12. Procedural safeguards
13. Policies and procedures for personnel standards
14. System for compiling data on the early intervention programs

other representatives of the appropriate agencies involved in services (100 STAT, Sec. 682). The ICC's charge is to advise and assist the lead agency in carrying out its responsibilities. The primary mechanism for participation in state-level Part H planning is the ICC and its related task forces.

While stressing the importance of a coordinated, multidisciplinary, and comprehensive approach to services, Part H does not specify in detail how a state should ensure that each type of provider fits into the system of services envisioned by state planners. For Part H to function effectively, physicians will have an important role to play in a number of program components mandated by the statute. One very critical function physicians can play relates to early identification. Because of their early contact with infants, physicians and other primary health care providers are in a unique position to identify those in need of early intervention services (e.g., Palfrey, Singer, Walker, & Butler, 1987). The Part H Regulations give recognition to this important function by requiring states to establish referral procedures from physicians, hospitals, prenatal and postnatal care facilities, and a variety of other primary referral sources (United States Department of Education, 1989, Sec. 303.321(d)). Other components of Part H in which physicians play an important role include:

- diagnosing conditions (100 STAT., Sec 672(2)(E)(viii));
- evaluating a child's developmental status and need for early intervention services (Regulations, Sec. 303.12(d));
- developing an Individualized Family Service Plan (IFSP) that specifies the child's health status (Regulations, Sec. 303.322(c)) and health-related service needs Regulations, Sec. 303.344(e)(1-2)); and
- consulting with other service providers regarding the special health care needs of children that must be addressed during the course of providing other early intervention services (Regulations, Sec. 303.12(b)(1-2).

Under the Regulations, services that are purely "medical" in nature (e.g., corrective surgery, hospitalization for the management of a condition) are not provided under Part H (Sec. 303.13(c)(1)(i-ii)). The types of health services that are provided are defined as "services necessary to enable a child to benefit from the other early intervention services during the time that the child is receiving the other early intervention services" (Regulations, Sec. 303.13

(a)). Included among such health services are clean intermittent catheterization, tracheotomy care, tube feeding, etc. The Regulations imply that these health services will not be provided by a physician but may require his or her consultation with other providers.

The Regulations address the need to plan broadly for a child's medical/health needs in two ways. First, health services not provided under Part H are to be specified in the Individualized Family Service Plan (Sec. 303.344). Second, the Part H case manager is allowed to assist the family in procuring the health services which are not provided under this program (Sec. 303. 314).

While the statute and Regulations set forth the broad parameters of physician participation, states are left with the task of designing policies and procedures for promoting collaboration among community-based health care providers and other constituents of the Part H system. In light of the strong national impetus in support of normalization, it is helpful to see this as a problem of integrating Part H into the broader array of services and service niches that families typically utilize for infants and toddlers who are <u>not</u> experiencing delays. A large proportion of the "normal" service niches for infants involve community-based medical/health providers. In order for Part H to function effectively, state and local policies and procedures for a coordinated system of referrals from community-based primary care providers and for multidisciplinary assessment must be workable in the context of clinical practice. It is critical, therefore, to involve physicians in planning these policies and procedures.

Participation in planning appears to be essential to the fostering of a sense of "ownership" among <u>all</u> the key planners and providers of services in a comprehensive, coordinated program of early intervention. This is perhaps even more important for the private medical sector, since there are no institutional structures, few mechanisms, and no lines of authority within the community of private practitioners for "getting the word out" and ensuring wholehearted cooperation. Further, there is often a history of frustrated relationships between private physicians and public agencies.

The challenge of developing effective policies and procedures for facilitating physician participation in Part H has received rather less attention than its importance would suggest. Since states are still planning for implementation, the logical place to begin an examination of this issue is to explore the extent to which physicians have participated in policy development. This initial study, therefore, focuses on physicians' involvement in state-level Part H planning.

METHOD

Respondent Sample

Since the primary vehicle for involvement in state Part H planning is the Interagency Coordinating Council, we asked physicians serving on ICCs to participate in this research. To supplement the ICC sample, we also surveyed state chapter representatives who attended the American Academy of Pediatrics' (AAP) National Conference on Public Law 99-457, held in November, 1988 (co-sponsored by the Bureau of Maternal and Child Health and Resources Development; see American Academy of Pediatrics, 1989). By adding to our sample those state chapter representatives who were not ICC members, we sought to include additional physicians attuned to Part H policy issues.

We identified the ICC physicians through each state's Part H coordinator, who was asked to provide us with the names and addresses of all physicians who served currently or previously on the ICC, either as voting members or as regular participants on related task forces. We identified the non-ICC physicians through the list of state chapter representatives at the November AAP conference, which one of our research team attended.

In all, a total of 146 physicians were identified for the sample and 125 completed the survey. The 86% response rate to the survey is remarkable, offering testimony to the strong interest these physicians take in early intervention services.

Of the final sample, 86 were ICC physicians, with 25 states having more than one physician serving on its ICC. Only six states reported having no physicians on their ICCs. The remaining 39 respondents were AAP conference attendees who were not routinely involved in the work of the ICCs. It should be noted that many state chapter representatives at the AAP conference were ICC members: we grouped their responses with the other ICC respondents, treating only non-ICC conference attendees separately.

Survey

A written survey instrument was designed to examine areas of Part H planning where medical knowledge and an understanding of the context of medical practice are especially relevant to the design of workable and effective policies. The survey instrument was developed by a collaborative team, drawn from the Department of Community Pediatrics, the Health Services Research Center, and the Carolina Policy Studies Program, all based at the University of North Carolina at Chapel Hill.

The survey instrument was pilot-tested, using 19 physicians serving on the ICCs in seven states. Pilot-test respondents were encouraged to offer suggestions regarding the instrument. Input from their responses resulted in minor changes to the instrument, which was then mailed in February, 1989, to physicians in the remaining 43 states. A second follow-up mailing went out in March. The survey instrument is included with this report in Appendix A. Two team members reviewed each returned questionnaire and coded the open-ended items. Inter-coder agreement exceeded 85%.

Scope

The results of this survey reflect the insights and opinions of a very select group of physicians who have taken an active role and keen interest in policy development for Part H. This sample does not necessarily represent the views of community-based practitioners regarding the impact or effectiveness of the Part H system. Indeed, we felt that prior to full implementation, it would be premature to turn to the wider community of physicians. Nor does

our sample encompass all the physicians who over the years have provided leadership in addressing the special needs of children with developmental delays and their families.

There are several points to bear in mind regarding the sample sizes reported for different items. First, findings for ICC physicians include multiple respondents for some states. Therefore, when we report that 30 respondents indicated no policy had been developed on a topic, we do not mean that 30 states have yet to develop this policy. Second, findings that pertain to the status of policy development or to areas of participation in state Part H planning are based solely on ICC physicians' responses. We chose to confine our focus in this manner, because during this planning phase draft policies undergo many changes. Those routinely engaged in policy development are the best informants on evolving policy. Third, occasionally respondents did not answer an item: this contributes to slight variability in the number of respondents for individual items.

RESULTS

Who are the Physicians on ICCs?

With many states having more than one physician actively and regularly involved in ICC work, it seemed useful to consider the different types of professional experiences these physicians bring to Part H planning. We, therefore, asked respondents to identify their primary professional work settings and we categorized those settings into three groups that offer distinct and complementary perspectives on planning.

- Private Practitioners. Of all the private providers involved in services to infants with handicaps, private physicians hold a unique position. Unlike professionals from other disciplines, their income often derives exclusively from their own practice. Further, private practitioners typically handle a patient "solo", rarely working in an interdisciplinary team context. The private physician, therefore, brings to Part H planning a knowledge not only of medicine but also of the context of private practice, which is critical to assessing the feasibility of proposed policies.
- Institution-based Practitioners. In our sample, the institution-based physicians typically practice in settings with a strong focus on neonatal care or the evaluation and treatment of youngsters with delays or chronic conditions. Their extensive experience with the Part H population is relevant to many key policy issues, such as eligibility and assessment. These physicians often participate in team assessments or

consultation. Further, the context of their practice affords them ready access to the input of medical colleagues regarding proposed policy.

- Government Administrators. Many of the physicians responding to this survey served as administrators in government agencies, such as Title V programs in departments of public health. These physicians understand program implementation, including issues in the distribution of services, the shortage of qualified personnel, and the restrictions on fiscal resources. They are also sensitive to procedural issues that can serve as disincentives to collaboration (e.g., paper work for Medicaid). Their experience as policy makers and administrators complements their medical training in planning for Part H.

The ICC physicians (n=86) in our sample were divided almost evenly among private practitioners, institution-based practitioners, and government administrators (Table 2). The non-ICC respondent pool (n=39), by comparison, includes a lower percentage of government administrators and higher percentages of the other two groups.

Because coordination between the public and private sectors is so critical to effective Part H implementation, it is notable that almost half the states (24) represented in the sample reported no private physician involved routinely with the work of the ICC.

Ninety-four percent of the ICC physicians were pediatricians. Of these pediatricians, almost two-thirds had received postdoctoral training in specialty areas such as developmental/behavioral pediatrics and neonatology. While the involvement of pediatricians is crucial, the marked absence of family practitioners in Part H planning is a concern. Many states have either large geographic areas that lack pediatricians or significant segments of the population who do not see pediatricians for the care of children. Thus, the lack of representation from family practitioners is a potential problem unless other processes and mechanisms are developed to draw this group into the Part H communication loop.

Views on Eligibility

Prior to the passage of Part H, definitions and criteria for eligibility for early intervention services varied greatly among states (Gallagher, Harbin, Thomas, Wenger, & Clifford, 1988). Part H requires states to develop policies regarding who will be served, which must include a definition of developmental delay and the criteria for determining eligibility. Many states have placed a priority on developing eligibility policies, since decisions concerning

Table 2. Types of Primary Professional Settings in which Sample Physicians Work

	TYPE OF RESPONDENTS					
	ICC Members (N=86)		Non-ICC Respondents (N=39)		All (N=125)	
Professional Setting	N	%	N	%	N	%
Private Practice	28	(33%)	17	(44%)	45	(36%)
Institution-based Practice	27	(31%)	15	(39%)	42	(34%)
Government Administration	31	(36%)	7	(18%)	38	(30%)

many of the other 13 program components required by Part H, such as Child Find (see Table 1 above), will depend in part upon which youngsters will be eligible for services (see Harbin, Terry, & Daguio, 1989).

Physicians' participation in the development of eligibility policy is especially important, first, because of their knowledge of diagnostic evaluation as well as the developmental outcomes and medical implications of many conditions. Second, if all children in need of services are to be successfully identified, physicians throughout a state must be informed fully about eligibility criteria and feel comfortable with referral under these criteria.

Eligibility Criteria. Since those individuals engaged in Part H policy development are the most informed regarding draft policies, we focused on the 86 ICC physicians' responses regarding the status of eligibility policy. Almost 90% of the ICC physicians reported that they had been involved in developing their states' definitions of developmental delay. Using a five-point scale, ranging from "disagree completely" (1) through "agree completely" (5), we asked the respondents to rate the extent to which they were in agreement with the draft criteria produced (Table 3).

Fifty-three of the 86 ICC physicians reported that their states had developed draft criteria to determine developmental delay at the time of the survey (February - March, 1989). Only one respondent expressed complete disagreement with the criteria; another five disagreed to some extent. Thus, just over 11% rated their views as falling somewhere within the "disagreement" range. Another 36% scored themselves as agreeing to some extent, and 53% indicated complete agreement. One way to look at these results is that 47%, or nearly half of the respondents, stood in less than full agreement with the draft criteria. Another way is to note that almost 89% expressed moderate to full agreement with the draft policy.

At-risk. In addition to developing the definition and criteria for assessing developmental delay, states must also decide whether to serve infants "at-risk" for delay under Part H and

Table 3. ICC Physicians' Level of Agreement with the Criteria to be Used by Their States to Determine Eligibility (N=53)[a]

	Respondents	
Level of Agreement	N	PERCENT
Disgree Completely	1	2%
Somewhat Disagree	5	9%
No Opinion	0	-
Somewhat Agree	19	36%
Agree Completely	28	53%

[a] Thirty physicians reported no draft criteria had been developed; 3 did not complete the question.

which risk factors to specify as constituting eligibility. We wanted to learn about physicians' perspectives on the inclusion of at-risk youngsters under Part H, regardless of the direction being taken by state policymakers. For this purpose, current knowledge of draft state policy was not essential; therefore, our respondent pool includes both ICC and non-ICC physicians. Of the 125 respondents, 120 offered responses on the biological risk item and 122 on the environment risk item (Table 4).

On the questionnaire, we asked respondents for their personal opinions regarding the eligibility of children biologically or environmentally at-risk. The two items on risk allowed respondents to specify their views on the degree of inclusion from "no biologically [environmentally] at risk children should be eligible" (1) to "all biologically [environmentally] at risk children should be eligible" (3). Only two and five respondents, respectively, selected the "no opinion" option on the two items. We did not define these two types of risk for our respondents, because our goal was to develop a broad profile of opinion on these aspects of Part H eligibility. Nor did we seek to determine respondents' opinions on which specific factors to include within each type of risk, much less on the cumulative risk associated with the effects of multiple risk factors interacting over time (e.g., Kochanek, Kabacoff, & Lipsett, 1987; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987). The results we report, therefore, should be seen as a very simple and rough gauge of opinion on at-risk inclusion.

Biological Risk. All respondents felt that at least some biologically at-risk children should be eligible for services, while 72% felt that all biologically at-risk should be eligible. Since state agencies would have to bear the burden of providing services to these youngsters, it seemed possible that those physicians who were agency administrators would be less disposed to include biological risk among the eligibility criteria. This was not the case. In fact, state administrators were the group most strongly in favor (79%) of serving all biologically at-risk children, with private and institution-based practitioners 68% and 69% in favor, respectively.

Table 4.

PHYSICIANS FAVORING THE INCLUSION OF BIOLOGICAL OR ENVIRONMENTAL RISK FACTORS AMONG PART H ELIGIBILITY CRITERIA

RISK FACTOR	ALL RESPONDENTS		TYPE OF WORK SETTING					
			PRIVATE PRACTITIONERS		INSTITUTION-BASED PRACTITIONERS		GOVERNMENT ADMINIS-TRATORS	
	N	%	N	%	N	%	N	%
BIOLOGICALLY AT RISK (N=120)								
none	0	-	0	-	0	-	0	-
some	34	28%	14	32%	13	31%	7	21%
all	86	72%	30	68%	29	69%	27	79%
ENVIRONMENTALLY AT RISK (N=122)								
none	2	2%	1	2%	1	2%	0	-
some	56	45%	19	42%	20	48%	17	49%
all	64	53%	25	56%	21	50%	18	51%

Environmental Risk. Consensus on the desirability of including environmentally at-risk youngsters was also strong. All but two respondents thought at least some environmentally at-risk youngsters should be eligible for services. Looking at the group as a whole, just over half (53%) thought all environmentally at-risk youngsters should be served. Again, we thought it possible that the physicians working in state agencies would be more reluctant to serve the environmentally at-risk group because of the fiscal implications. However, the differences among private practitioners, institution-based practitioners, and government administrators were small.

The Two Types of Risk Considered Together. Although we did not ask respondents to consider the inclusion of biological and environmental risk together, we examined the joint distribution of these two items to see how responses on each fit together. Respondents expressed an overwhelming sentiment in favor of a broad set of eligibility criteria. Ninety-eight percent of these physicians thought some combination of biological and environmental risk factors should be included among the eligibility criteria (e.g., respondents could choose "all biologically at-risk children should be eligible" on one item and "some environmentally at-risk children should be eligible" on the other item). Perhaps more significantly, over 50% of these physicians expressed the opinion that all children at-risk under each of these categories should be eligible for Part H.

We report this pattern with caution, however, for several reasons. First, the survey went out before the promulgation of the Regulations, which might have inspired greater caution. Second, we did not ask respondents to express their views on the two types of risk in combination. And third, we did not seek responses based on a particular definition of either type of risk or on specific risk-factors. Nonetheless, in view of most respondents' concerns about the major barriers to implementation (discussed later), it seems useful to identify a possible source of value conflict here. Many respondents expressed the view that low levels of funding in support of Part H would be an obstacle to full implementation: limitations on fiscal

resources will surely be exacerbated by broad eligibility criteria. A few respondents, in fact, stated that proposed eligibility policies could aggravate the shortage of resources.

Policy Planning Areas in Which ICC Physicians Have Been Involved

We chose policy areas in which the input of physicians is especially pertinent to comprehensive planning and asked the ICC physicians whether and how they had been involved in each (Table 5). Eighty-three of the 86 ICC physicians provided information on the areas in which they had participated in planning.

Respondents reported considerable involvement in various aspects of Part H planning, with most engaged in more than one issue area. Over 85% of the ICC physicians reported having been involved in the development of 1) the definition of developmental delay and 2) policies related to Child Find and screening. Other areas in which they reported considerable involvement were professional continuing education (84%), diagnostic assessment and screening (83%), coordination of services (80%), tracking and data collection (77%), case management (77%), IFSP (71%), and central directory (69%). The area in which they were least involved was coordination of finances (59%), a policy area in which little progress has been made by states so far (Harbin, Gallagher & Lillie, 1989), but about which physicians expressed concern (discussed later in this report).

The primary functions served by these physicians in policy development included planning and task force participation (97%) and reviewing draft plans (90%). Another function served by just over 70% of the respondents was seeking input from the medical community. There is reason for concern in this last finding, especially since we did not ask <u>how systematically</u> input from the medical community was sought. For the purposes of planning a collaborative system, there is some evidence here that more effort to gain input systematically from the medical community is in order.

Table 5. Part H Policy Areas for Which ICC Physicians Reported Participation In Planning (N=83)

Policy Area	Repondents Indicating Involvement[a]	
	N	Percent
Child Find/Screening	74	89%
Developing the Definition of Developmentally Delayed	72	87%
Professional/Continuing Education; Personnel Development	70	84%
Diagnostic Assessment	69	83%
Coordination of Services	66	80%
Tracking/Data Collection	64	77%
Case Management	64	77%
Development of the Individualized Family Service Plan	59	71%
Central Directory of Resources and Services	57	69%
Coordination of Finances	49	59%

[a] A respondent could report more than one area of involvement.

Views Regarding Physicians' Role on the Multidisciplinary Team

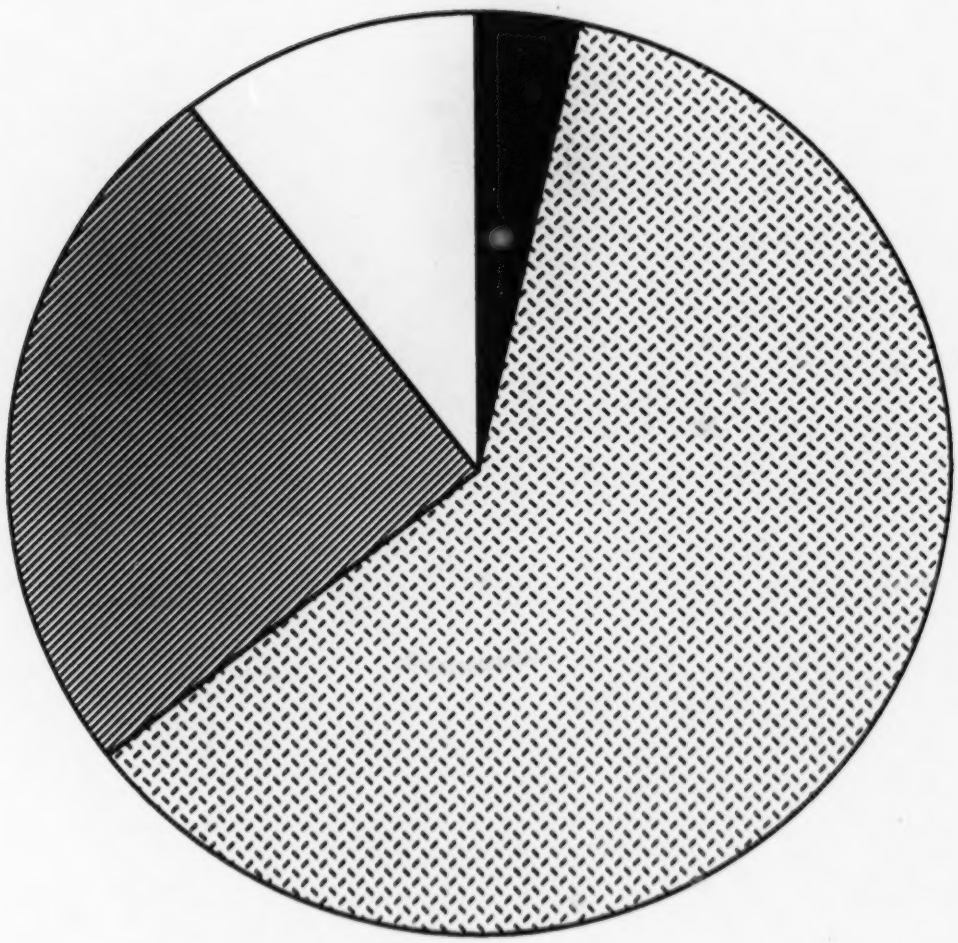
Under Part H, the determination of a child's and family's service needs occurs through a multidisciplinary team assessment. The service plan (IFSP) that emerges provides a comprehensive view of the child's developmental and health status. This service plan, developed through the collaboration of relevant professionals and the family, is meant to include a full portrait of the child's medical/health service needs and the steps to be undertaken in order to procure services, even if such services are not required under Part H (Regulations, Sec. 303.344(e)(1-2)).

The importance of medical input to the evaluation and assessment process is apparent, although the precise role of physicians on the multidisciplinary team has been a matter of debate. We asked the respondents what they saw as their primary role within the multidisciplinary team, regardless of the status of their state's policies on the IFSP or the case management plan. Our sample for this question includes both ICC and non-ICC physicians: 122 of the 125 respondents provided answers to this item.

The majority (almost 60%) saw their primary role on the team as an equal participant, with their role varying according to the individual case (Figure 1). Only three respondents (3%) expressed the view that they should function as a chairperson of the team. Substantial percentages, however, saw their primary roles to be "regular provider of health information to the team" (24%) and "consultant upon request" (14%). Only two respondents felt physicians should play no primary role on the team.

The pattern of responses clearly indicates that respondents see physicians as having a significant role to play within the multidisciplinary processes of assessment and IFSP development. This view makes good sense in light of the special health needs of many eligible infants and toddlers and the goal of planning for the full range of service needs. One excellent reason for engaging physicians in Part H planning is to design mechanisms and procedures that facilitate physician participation in the multidisciplinary team processes.

Figure 1.
Physicians' Opinions on the Primary Role They Should Play on the Multidisciplinary Team (N=122)



KEY:
- Non-Participant (2%)
- Equal Participant, Leadership when appropriate (58%)
- Regular Provider of Health Information (24%)
- Consultant upon Request (14%)
- Chairperson (3%)

Provision of Early Intervention Prior to Part H

We asked respondents to rate how well they felt their states were doing in the provision of a number of service components required by Part H prior to the enactment of the law. The components were:

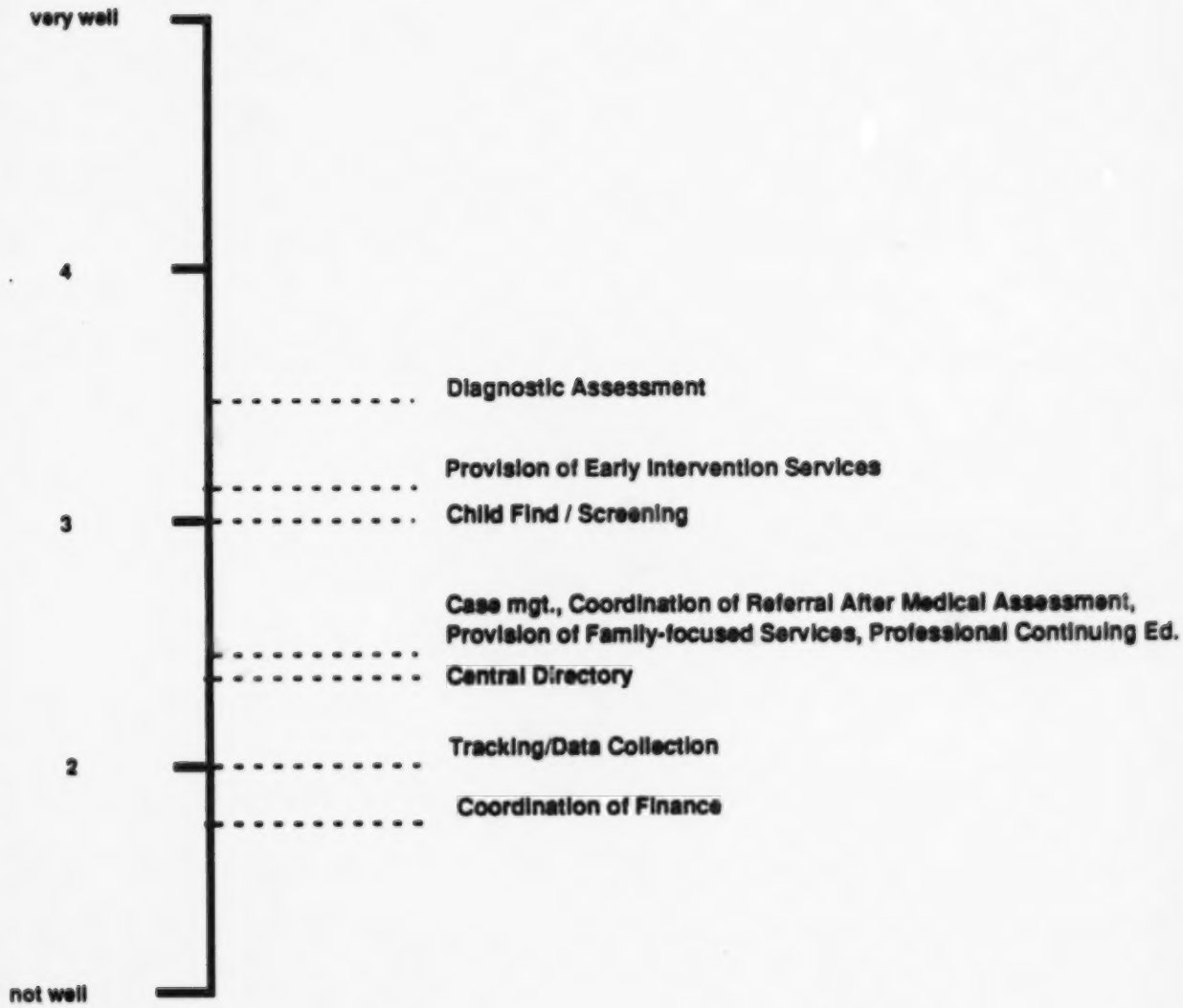
- Tracking/Data Collection
- Coordination of Finances
- Case management
- Central Resource Directory
- Provision of Family-focused Services
- Coordination of Referral after Medical Assessment
- Professional Continuing Education

Respondents rated each component on a 1-5 scale, with (1) representing "not well" and (5) representing "very well." Since rating the pre-Part H status of services does not depend on current involvement in planning, we report on responses from both ICC and non-ICC physicians. Of the 125 physicians in the final sample, 119 answered all rating scale items.

In order to obtain an overall rating of early intervention services, we summed the ratings for components and derived a mean. This overall mean rating was 2.6, indicating that respondents tended to see their states as slightly below the midpoint between "not well" and "very well." Similarly calculated mean ratings for each of the three groups were nearly identical.

Respondents did not rate states' provision of all the pre-Part H early intervention components equally (Figure 2). Treating the sample as a whole, respondents tended to rate diagnostic assessment, the provision of early intervention services, and Child Find as slightly above the midpoint on the continuum from "not well" to "very well." They rated other components below that midpoint, with tracking/data collection and coordination of finance rated lowest. Considering the scale's narrow range, the difference between the ratings of components at the top and the bottom is considerable. Again, the three groups of physicians were remarkably similar in the ratings assigned to different service components, with full consensus on the three highest and three lowest ranking components.

Figure 2. Physicians' Ratings of How Well Their States Did Relative to Providing Service Components of a Comprehensive Early Intervention System Prior to the Enactment of PL 99-457 [a] (N=119)



[a] Mean rates were computed for each component

Relationship between Public and Private Sectors

Since establishing a workable interface between the private health sector and the public human service system is so crucial to Part H, we wanted to see if ICC physicians saw any changes associated with the enactment of the law. We asked respondents to rate the private health sector/public human service system relationship prior to Part H and currently on a five-point scale. The scale ranged from "not at all effective" (1) to "very effective" (5). Eighty of the 86 ICC respondents completed the two ratings.

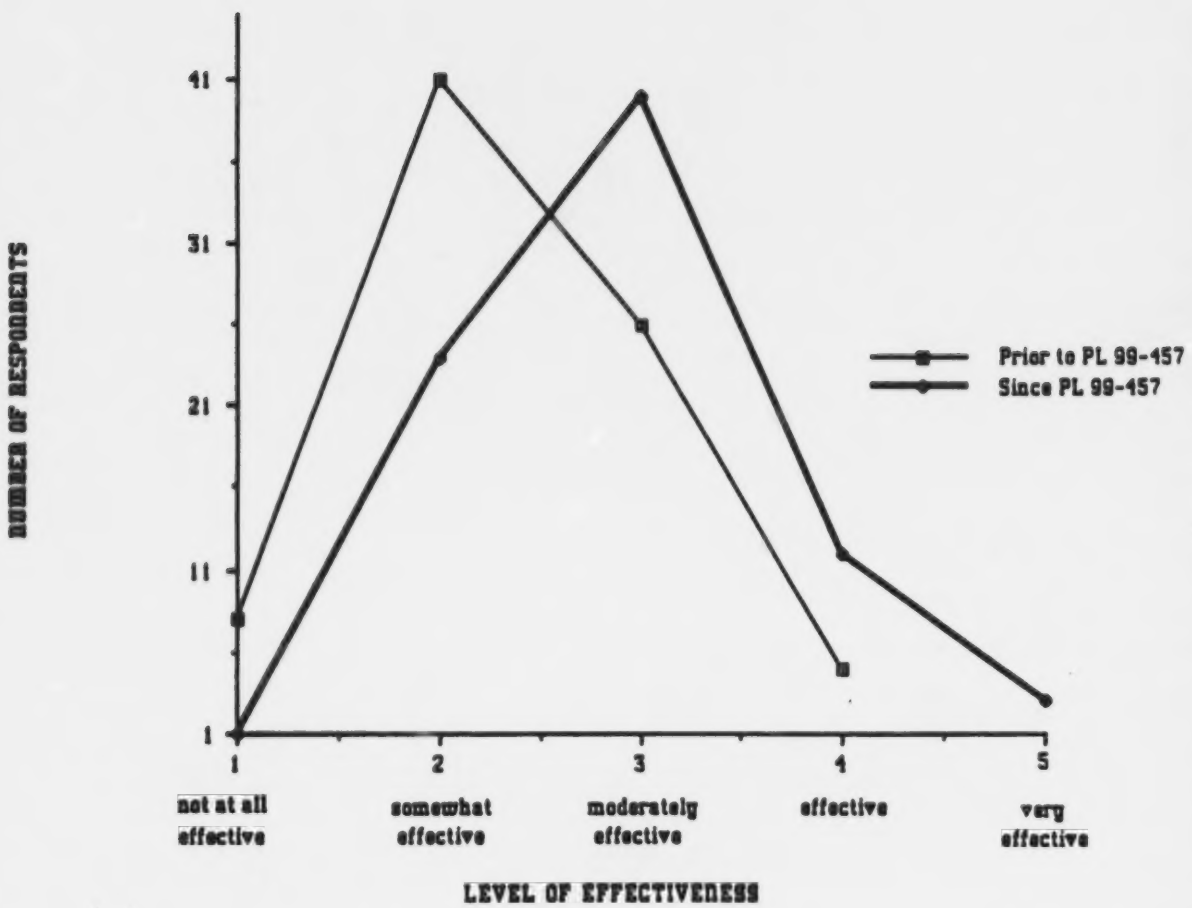
In Figure 3, we present a graphic comparison of how ICC physicians rated the public/private sector relationship prior to Part H and currently. Respondents reported modest improvement since the commencement of Part H planning. Since states are only in the beginning phase of implementation, we see this as a positive sign. State administrators tended to view the relationship between the public and private sectors slightly more positively than practicing physicians, both before and since the enactment, but this difference was very small.

Barriers to Implementation

In order to determine what both ICC and non-ICC physicians saw as major barriers to the full implementation of Part H, we asked them to identify the obstacles they observed in their states. This was an open-ended response item, for which respondents could identify as many barriers as they wished. For this reason, "non-mentions" should be viewed with caution. The fact that a respondent did not mention a barrier does not indicate (s)he thought it unimportant, but rather that it did not come to mind when answering the question. Had this been an item for which a list of response choices were provided, the absence of an item would provide a better indication that the respondent felt it unimportant.

Funding and Reimbursement. Despite the fact that the open-ended item left scope for diversity, there was remarkable agreement on the major barriers. Of the 118 (out of 125) physicians offering opinions on this item, 64% identified fiscal issues as the foremost barrier

Figure 3. ICC Physicians' Estimation of Effectiveness of the Relationship between Public Human Services and Private Health Sector, before and after the Enactment of PL 99-457 (N=80)



(Table 6). Included within this category are concerns about the inadequate federal support for Part H and, in many states, the lack of state fiscal commitment.

Some respondents also raised concerns about a variety of difficulties surrounding reimbursement. One problem derived from differential reimbursement for "procedural" and "cognitive" medicine. The latter includes activities such as, "consulting," "planning," and "case management" (i.e., the types of activities that characterize the work of multidisciplinary teams). These activities are not always reimbursed or are reimbursed at rates substantially lower than those for procedures (e.g., surgery). Ironically, the "cognitive" medicine components of working with handicapped children are often more time-consuming than the actual procedures. In fact, the time-consuming nature of work with children with special needs is a major disincentive to private physicians serving these youngsters. Consultative activities lie at the heart of coordinated and comprehensive planning for the individual child and family, as well as for local or regional planning among professionals. Thus, differential reimbursement policies work against the spirit of Part H.

Another reimbursement problem relates to diagnosis. Not all insurers reimburse for every type of diagnosis. Some physicians noted the need to modify reimbursement policies but in the interim to cross-classify diagnoses in order to maximize coverage under current reimbursement policies.

The respondents also underscored the difficulties of financial coordination across agencies, programs, and other sources.

Interagency\Practitioner Coordination. The second most frequently mentioned barrier was the lack of interagency and practitioner coordination. Forty-five percent of the sample identified this obstacle. Encompassed in this category are a variety of problems, including the challenges of coordinating the efforts of autonomous agencies. From the perspective of the community-based physician, there is often an array of providers, each seemingly unaware of others' work. Some respondents reported that it was unclear where referrals should go and,

Table 6. Physicians' Views on the Major Barriers to the Full Implementation and Development of Health Services under Part H (N=118)

BARRIERS	RESPONDENTS[a]	PERCENT
Funding, reimbursement	76	64%
Lack of interagency/ practitioner coordination; turf; referral problems	53	45%
Lack of appropriately trained personnel; lack of available services	23	20%
Lack of understanding the law by providers	16	14%
Lack of interest, concern	14	12%
Lack of knowledge of what is needed; unclear roles	14	12%
Problems with eligibility criteria	11	9%
Lack of leadership, appropriate representation	9	8%
Screening, tracking problems	6	5%

[a] A respondent could identify more than one barrier to implementation.

furthermore, that referrals seemed to fall into the abyss, with no follow-up provided back to the physicians. This resulted in the sense that responsibilities had not been fulfilled and served as a disincentive for further referrals on the part of local physicians.

Some respondents also reported that physicians readily refer to other medical specialists but are characteristically reluctant to refer to non-medical providers. Some comments, however, also indicated that difficulties of turf/"ownership" also occur among medical practitioners, who were cited as sometimes unwilling to "let go" of a child even when professionally and medically appropriate. A few respondents expressed concern that some community-based physicians remain unconvinced regarding the efficacy of early intervention.

Finally, some respondents mentioned a barrier of "jargon" that impedes communication between the physician and other interventionists: the terminology used by special educators in particular is often very different from that of physicians. The net result is that physicians can easily lose interest in participating in case conferences.

Appropriate Personnel and Services. The third most frequently mentioned (20%) barrier was the shortage of qualified personnel of all types needed to provide a full array of services to eligible children in all regions of the state. This concern pertained to all types of personnel and services. Some respondents, however, stressed the training needs of physicians, especially of private practitioners, who rarely work in team contexts and who may have limited experience with the Part H population and their service needs.

Other Barriers. Other obstacles mentioned were a) a lack of provider understanding of the law (14%), b) inadequate knowledge of what is needed to achieve implementation and the absence of clarity regarding the roles of different players (12%), c) a lack of interest among physicians in serving the eligible population (12%), and d) lack of leadership and inappropriate or inadequate representation of relevant constituents in the planning process (8%). A few respondents also indicated that problems associated with eligibility criteria or screening/tracking were barriers to implementation.

Perspectives Compared. In Figure 4 we compare the major barriers mentioned by private practitioners, institution-based practitioners, and government administrators. For each group, we calculated the percentage of respondents mentioning each barrier to implementation. All three groups placed heavy emphasis on funding/reimbursement and interagency/practitioner coordination as obstacles to implementation.

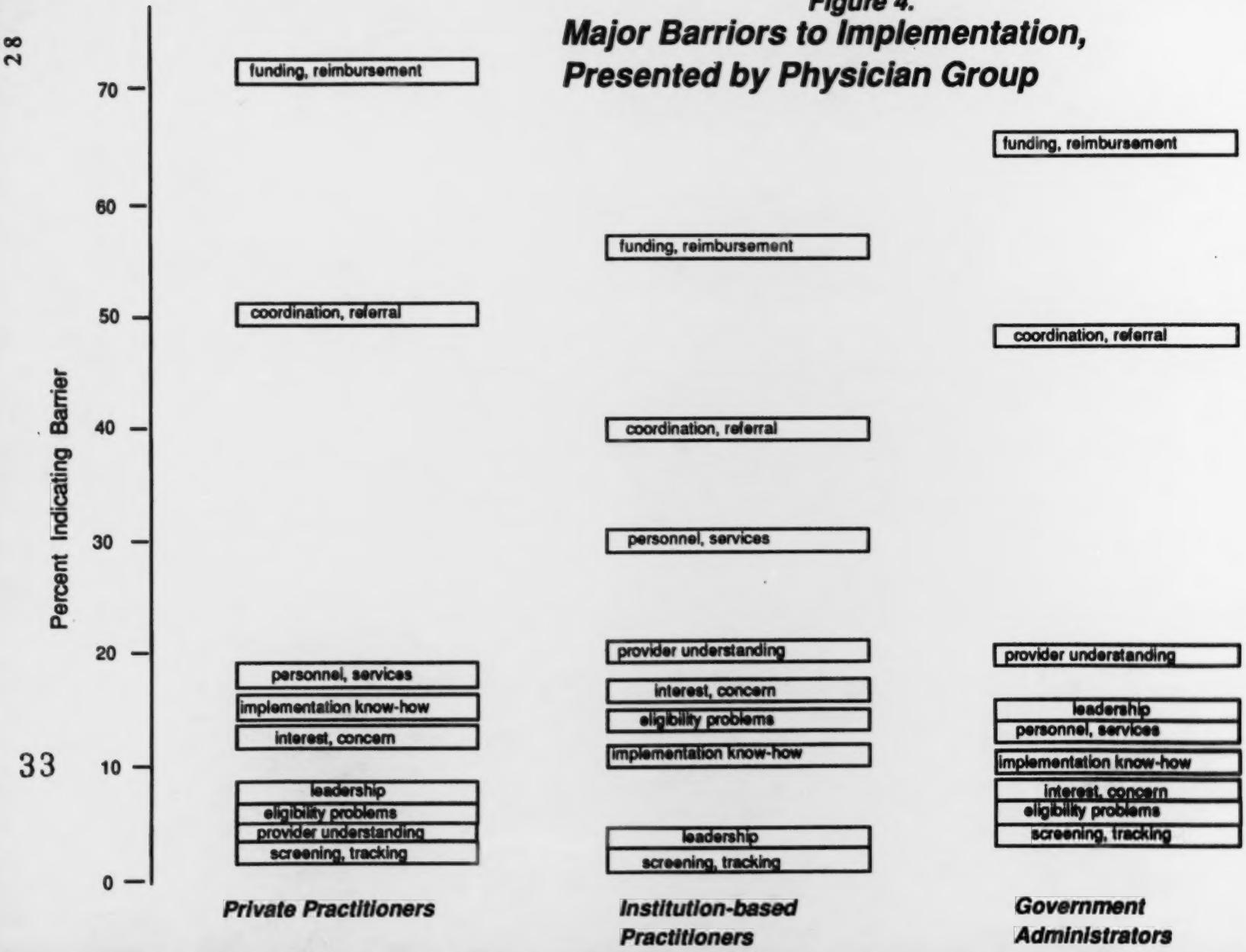
Even though all three mentioned the same two barriers most frequently, the groups seem to differ in their level of concern about those barriers. Institution-based practitioners mentioned funding/reimbursement (54%) and interagency/practitioner coordination (39%) substantially less often than private practitioners (funding - 72% and coordination - 49%) and somewhat less often than government administrators (funding - 64% and coordination - 47%). It may be that the institutional context of practice facilitates coordination and cushions the impact of funding/reimbursement problems, thus making these obstacles less salient to this group.

Second, institution-based practitioners focused on the lack of appropriate personnel and services (28%) more frequently than did either private practitioners (16%) or government administrators (14%). This pattern reflects the concerns of developmental/behavioral pediatricians and neonatologists, who make up a large proportion of institution-based practitioners in the sample and who are especially aware of the specialized skills involved in serving eligible children.

Another difference of some magnitude is that both institution-based practitioners and government administrators raised concerns about providers' limited understanding of Part H. This difference in perspective might be reflective of the fact that private practitioners do not have as extensive contact with providers around the state as do their counterparts in our sample..

The pattern of responses suggests strong consensus among the surveyed physicians regarding the greatest barriers to implementation. Differences among the three groups, while set forth with caution, seem suggestive of the distinct perspectives they bring to the enterprise

Figure 4.
Major Barriors to Implementation, Presented by Physician Group



of policy making and underscore the need to involve a variety of physicians in planning for Part H.

DISCUSSION

Our findings indicate a keen interest in and commitment to Part H among the core group of physicians actively involved in state-level policy development. This commitment provides the minimum base support necessary for designing a Part H system that effectively identifies youngsters at the earliest age and articulates with the "normal" array of community-based service providers typically utilized by for families for infants. While our respondents expressed the view that levels of cooperation between the public human service system and the private health sector are improving, there are a number of concerns and issues raised by the findings.

We chose for our study a very select group of physicians who have an inside vantage point on state Part H activities and a strong interest in public policy. During the planning phase of Part H, this is the most appropriate group to offer insights into issues in policy development from the physician's perspective; however, it is important to raise concerns about the representativeness of our findings with regard to the wider medical community. With only 36% of the respondents engaged in private practice, community-based physicians are relatively under-represented in state-level Part H planning. In our analysis, we attempted to identify any differences between the views of the private community-based physicians and their institution-based or government-based colleagues, and few were found. It appears that the select group of community-based physicians represented in our sample shared the views of the larger group. It remains to be seen whether the wider constituency of community-based physicians, who are presumably less involved in the care of developmentally disabled children, will share our respondents' views or will participate in Part H over time.

Another concern is that six states reported having no physician participation in Part H planning through the ICC or related committees and task forces. Although effective coordination

often actually occurs at the local level, there is some concern that without adequate physician involvement at the state policy-making level, local coordination may not evolve with equal effectiveness throughout a state. A proposed amendment allowing states to expand ICC membership may help this problem by allowing governors to appoint more members to ICCs.

A third area of concern is that those private practitioners involved in planning represent only a very few family and general practitioners. Yet, in parts of some states these medical practitioners see the majority of toddlers and are an important source of referral. Thus, while the relationship between those designing Part H policy and the pediatric community has not always been optimal, the relationship with the community of family and general practitioners is even less well-established. It seems important to find ways to involve more private practitioners, and more family practitioners in particular, in planning for Part H. The AAP (1989) recently encouraged outreach to family practitioners regarding Part H; lead agencies and ICCs, therefore, can work with state AAP chapters to support this effort. One strategy for addressing the problem of informing and involving the wider community of physicians is the use of newsletters. The Colorado Part H program, for example, helps to fund several newsletters, one of which is produced by the AAP chapter and is sent to both family practitioners as well as pediatricians.

Another strategy for involving the wider medical community is to include physicians systematically in planning for services at the local level, since from the viewpoint of families and community-based physicians, much of the real work of coordination will need to occur at this level. States need to consider how to facilitate the development of structures (e.g., advisory groups, local ICCs), mechanisms, and processes (e.g., focus groups) that promote such participation. Ohio, for example, has developed 88 local collaborative councils (local ICCs), which conduct needs assessment, write local plans for coordinating early intervention services, and set local policies. The majority of these councils have physician representation, and the state is working with the AAP chapter to identify physicians for those local councils currently lacking medical representation.

A fourth concern has to do with the widely-expressed need to provide physicians with training relevant to participation in Part H. Respondents mentioned the need for physician training in screening and assessment, multidisciplinary team process, referral procedures, awareness of community resources, and atypical development. They also noted the need to provide the wider medical community with a basic understanding of the Part H program, eligibility policies, and early intervention. One state that has placed special emphasis on continuing education for physicians is Hawaii, which has developed a program of outreach to local physicians and training through the Physician Involvement Project (Sia & Peters, in press), funded through grants from the Office of Maternal and Child Health and Resources Development. As part of a broader effort to promote a comprehensive system of care, the Physician Involvement Project (PIP) has developed and implemented a Continuing Medical Education course in close collaboration with the AAP chapter and medical school. The course, which revolves around the concept of the "medical home," provides training in community-based coordinated, family-centered care, with special focus on community resources, the promotion of team participation, and interagency networking. The Part H program has benefited from the commitment fostered by the PIP through broad-based and informed support for the early intervention effort in the medical community throughout the state.

A fifth area of concern is that problems of reimbursement seem to play a critical role in blocking the participation of community-based practitioners. As mentioned earlier, if reimbursement policies preclude or devalue time spent planning and consulting, then the potential for physician participation on multidisciplinary teams, local ICCs or advisory groups, and in other coordinating activities is limited. Some states have sought to address these problems by revising reimbursement policies. South Carolina, for example, has begun to reduce reimbursement barriers through the state's Medicaid Program, which has developed expanded reimbursement codes. These allow Medicaid to reimburse "unbundled" specialized evaluation services (i.e., rather than to reimburse an evaluation at a flat rate, Medicaid can reimburse separate specialized components of a multidisciplinary evaluation as well as to

reimburse home-based evaluations and parent training). Embedded in the expanded codes is case conference time. Additional reimbursement codes pertaining to Part H case management are also being developed by the state's Medicaid Program.

A policy concern closely related to reimbursement problems has to do with HMO's. A few respondents specifically noted that HMO management strategies are designed to minimize the amount of physician time spent with any one patient and the number of referrals to specialists outside HMO. Children eligible for Part H, however, often require considerable consultation time and need the care of specialists. If the state does not pick up the costs of these services, families using HMO's might not be as readily referred into the Part H system. The respondents emphasized the need to address how HMO's will fit into Part H.

A sixth concern has to do with the extent to which the initial enthusiasm of this select group of respondents can be maintained as the thorny problems of implementation begin to emerge. Some potential sources of stress and conflict were suggested in responses to the survey. Respondents listed the lack of funding as a major barrier to implementation. In view of this concern, it is somewhat ironic that the group favored eligibility for all biologically and many environmentally at-risk infants. The potential for conflict between available resources and the demand for services looms in these contradictory expectations.

This is a critical time in state Part H planning. If children are to be identified early and if the spirit of Part H is to be fully realized, it is crucial to plan the program of early intervention services so that it fits into the "normal" service niches utilized by most infants and families. For the Part H system to bridge the gap between the public and private sectors, policies must be formulated that:

- are rooted in sound medical knowledge regarding diagnosis, developmental outcomes, and health concerns related to a child's condition;
- represent workable solutions to the challenges of coordinating referrals and services between the private and public sectors;
- make sense within the context of clinical practice;

- encourage an awareness of and receptiveness to Part H in the medical community; and
- offer practical and clear solutions to problems on reimbursement.

States have taken a variety of approaches to involving physicians in Part H. Because of the complexity of the Part H program, it is clear that states must use multiple strategies to facilitating physician participation in early identification, referral, individualized planning, training, revision of reimbursement policies, and planning professional awareness campaigns. In a number of states, the first steps have been taken by including physicians on state and local ICCs, involving physicians in planning service components through direct contracting, developing methods for informing the wider medical community about the program, tackling reimbursement problems, and promoting professional training. Given the commitment of the AAP (American Academy of Pediatrics, 1989) and the Bureau of Maternal and Child Health and Resources Development (Bureau of Maternal and Child Health and American Academy of Pediatrics, 1989) to a program of community-based, family-centered, and coordinated services for children with special needs and a medical home for every child, it is an opportune time to address the challenges of public/private collaboration at both the state and local levels.

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APPENDIX A

ID Number /___/___/___/___/___/___/

APPENDIX A

Carolina Policy Studies Program

1 a. What is your primary specialty of practice (i.e.; the one in which you practice most of the time)?

_____

1 b. In what year did you complete your residency training in this specialty? _____

2 a. Have you completed a postdoctoral training program?

_____ (0) No (*Skip to question 3.*)
_____ (1) Yes

2 b. In what area did you receive training? _____

2 c. In what year did you complete this postdoctoral training program? _____

3. What is the primary setting of your practice? (*Check only one.*)

_____ (1) Private practitioner's office
_____ (2) Clinic practice focused on children with developmental disabilities (i.e.; DECs)
_____ (3) Prepaid group practice (i.e.; HMOs)
_____ (4) Hospital based specialty practice
_____ (5) Medical school based specialty practice
_____ (6) Other (*specify*) _____

4. What is your primary form of employment? (*Check only one.*)

_____ (1) Self employed or employee of a non-governmental employer
_____ (2) County or local government (not state)
_____ (3) State government
_____ (4) Federal government
_____ (5) Other (*specify*) _____

5. How long have you been working as a physician in this state (post-licensure)?

_____ years _____ months

6. Are you currently on or have you ever been on the Interagency Coordinating Council (ICC) for P.L. 99.457, Part H, the Handicapped Infants and Toddlers Program?

_____ (0) No (*Skip to question 9.*)
_____ (1) Yes (voting member)
_____ (2) Yes (ex officio, nonvoting)

7. For what time period are/were you serving on the Interagency Coordinating Council (ICC)?

from _____/_____/_____ to _____/_____/_____
month day year month day year

8. What percentage of your time does/did your activities on the ICC occupy?

_____ percent

9. Please rank the factors listed below from "1 = most influential" to "4 = least influential" in influencing your current involvement/interest in issues related to handicapped infants and children and their families.

_____ Residency/fellowship experiences
_____ Experiences in post-training practice
_____ Personal/family life
_____ Reading

10. If your state has developed a definition in compliance with P.L. 99.457, Part H, the Handicapped Infants and Toddlers Program, do you personally agree with the eligibility criteria which will be used to determine developmental delay in your state?

_____ (8) Definition not developed
_____ (1) Disagree completely
_____ (2) Somewhat disagree
_____ (3) No opinion
_____ (4) Somewhat agree
_____ (5) Agree completely
_____ (9) Not aware of P.L. 99.457, Part H definition

11. Regardless of your state's definition, what is your personal opinion regarding eligibility for children who are biologically at risk?

_____ (1) No biologically at risk children should be eligible
_____ (2) Some biologically at risk children should be eligible
_____ (3) All biologically at risk children should be eligible
_____ (4) No opinion

12. Regardless of your state's definition, what is your personal opinion regarding eligibility for children who are environmentally at risk?

_____ (1) No environmentally at risk children should be eligible
_____ (2) Some environmentally at risk children should be eligible
_____ (3) All environmentally at risk children should be eligible
_____ (4) No opinion

13. Regardless of the status of your state's Individualized Family Service Plan or Case Management Plan, how do you see your primary role within the multidisciplinary team? (*Check only one.*)

_____ (1) Chairperson, ultimate decision maker
_____ (2) Equal participant
_____ (3) Regular provider of health care information to the team
_____ (4) Consultant, when requested
_____ (5) Non-participant, but informed of options

14. Please indicate the nature of your involvement in **planning** for the following aspects required by P.L. 99.457, Part H, the Handicapped Infants and Toddlers Program. *(Check as many as apply.)*

		Planning/ task force	Reviewing draft plans	Publicizing plans to the general public	Seeking input from medical community	Not involved
a.	Child find/ screening	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)
b.	Tracking/data collection	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)
c.	Diagnostic assessment	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)
d.	Case management	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)
e.	Central directory of resources and services	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)
f.	Coordination of services	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)
g.	Coordination of finances	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)
h.	Development of an individualized family service plan	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)
i.	Professional continuing education/personnel development	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)
j.	Developing the definition of developmentally delayed	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)
k.	Other aspect(s) *(Specify)*	____ (1)	____ (1)	____ (1)	____ (1)	____ (1)

_____

_____

_____

_____

15. **Prior** to P.L. 99.457, Part H, the Handicapped Infants and Toddlers Program, how well did your state do relative to providing the following services to children, their families, and their health care providers? *(Circle the most appropriate number on a five-point scale.)*

		Not well				Very well	Don't know
a.	Child find/screening	1	2	3	4	5	9
b.	Tracking/data collection	1	2	3	4	5	9
c.	Diagnostic assessment	1	2	3	4	5	9
d.	Case management	1	2	3	4	5	9
e.	Central directory of resources and services	1	2	3	4	5	9
f.	Provision of early intervention services	1	2	3	4	5	9
g.	Coordination of finances	1	2	3	4	5	9
h.	Coordination of referral system after medical assessment	1	2	3	4	5	9
i.	Providing family focused services	1	2	3	4	5	9
j.	Professional continuing education	1	2	3	4	5	9

16. **Prior** to P.L. 99.457, Part H, the Handicapped Infants and Toddlers Program, in your opinion how effective was the relationship between the public human services system (including health, education, social services, etc.) and private health sectors in your state in serving infants and toddlers?

____ (1) Not at all effective
____ (2) Somewhat effective
____ (3) Moderately effective
____ (4) Effective
____ (5) Very effective
____ (9) Not sufficient information to evaluate

17. **Currently**, in your opinion how effective is the relationship between the public human services system (including health, education, social services, etc.) and private health sectors in planning for P.L. 99.457, Part H in your state?

____ (1) Not at all effective
____ (2) Somewhat effective
____ (3) Moderately effective
____ (4) Effective
____ (5) Very effective
____ (9) Not sufficient information to evaluate

18. Please describe what you see as the greatest barrier(s) to the implementation and development of health related services under P.L. 99.457, Part H, the Handicapped Infants and Toddlers Program in your state.

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19. Please list any official positions you <u>currently</u> hold in your state medical society or specialty association.

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20. If you were to advise pediatric house-staff training programs on the format of their teaching about P.L. 99,457, Part H, the Handicapped Infants and Toddlers Program and the treatment of handicapped infants, toddlers and their families, how would you rank the following methods? (Rank from "1 = most effective method" to "4 = least effective method.")

_____ Grand rounds
_____ Didactic sessions or series
_____ Individual precepting during residency training
_____ Required clinical/community experiences

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